UNIVERSITY of MARYLAND
UPPER CHESAPEAKE MEDICAL CENTER

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MEDICAL HISTORY FORM

Today's Date: _____

Patient Information
Please complete this form in its entirety and bring it with you to your scheduled appointment.

Name: _____ Birth Date: _____ Sex: ☐M ☐F

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Place of Residence: _____

Referring Physician: _____ Family Physician: _____

Reason for Referral: _____

Is this a MVA related injury? ☐ Y ☐ N • Is this a work related injury? ☐ Y ☐ N • Is this a non-work related injury? ☐ Y ☐ N

Are you diabetic? ☐ Y ☐ N • If yes, what was your last HgA1C Number? _____ • Where drawn? _____

Previous ulceration? ☐ Y ☐ N

Date of Onset: _____ Wound Cause: _____

Wound Treatment: _____

_____

Allergies: Include all allergies and reaction		

Medications: Include all medications, dosages and frequency.	
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

☐Please see attached

Pharmacy Name: _____ Phone Number: _____

Medical Background: Check all that apply (include date if applicable- month/year)		
☐ Acute Respiratory Syndrome	☐ Eczema	☐ Myocardial Infarction (MI)
☐ Adrenal Disease	☐ Emphysema	☐ Neuropathy
☐ AIDS	☐ End stage renal disease	☐ Obesity
☐ Alopecia	☐ Epidermolysis Bullosa	☐ Onychomycosis
☐ Alzheimer's	☐ Epilepsy	☐ Osteoarthritis
☐ Amyotrophic lateral sclerosis	☐ Fibromyalgia	☐ Osteomyelitis
☐ Anemia	☐ Fistula	☐ Osteoporosis
☐ Angina	☐ Fracture	☐ Pancreatitis
☐ Anticoagulant Therapy	☐ Fungal Infection	☐ Paralysis
☐ Anxiety	☐ GERD	☐ Paraplegia
☐ Arrhythmia	☐ Gestational Diabetes	☐ Peptic Ulcer Disease
☐ Arthritis	☐ GI Bleed	☐ Peripheral Artery Disease
☐ Asthma	☐ Glasses	☐ Peripheral Vascular Disease
☐ Assistive Devices	☐ Glaucoma	☐ Phlebitis
☐ Atrial Fibrillation	☐ Gout	☐ Pleural Effusion
☐ Benign Prostrate Hyperplasia	☐ Head injury/LOC	☐ Pneumonia
☐ Bipolar Disorder	☐ Heart Disease	☐ Pneumothorax
☐ Bleeding/Clotting Disorders	☐ Hemosiderin Staining	☐ Positive TB test
☐ Buerger's Disease	☐ Hepatitis	☐ Prostate Cancer
☐ Cataracts	☐ Hiatal Hernia	☐ Psoriasis
☐ Charcot Foot	☐ HIV Positive	☐ Pulmonary Embolus
☐ Chronic Bronchitis	☐ Hypercholesterolemia	☐ Pyoderma
☐ COPD	☐ Hyperlipidemia	☐ Quadriplegia
☐ Chronic Pain Syndrome	☐ Hypertension	☐ Raynaud's Disease
☐ Cirrhosis	☐ Immune Deficiency	☐ Respiratory Failure
☐ CNS Trauma/Spinal Cord injury	☐ Inflammatory bowel disease	☐ Retinopathy
☐ Colon Cancer	☐ Intracranial bleed	☐ Rheumatoid Arthritis
☐ Congestive Heart Failure	☐ Kidney disease	☐ Schizophrenia
☐ Contractures	☐ Kidney stones	☐ Scleroderma
☐ Coronary Artery Disease	☐ Leukemia	☐ Seizures
☐ Cortisone Treatment	☐ Lupus	☐ Sickle Cell Anemia
☐ Crohn's Disease	☐ Lymphedema	☐ Sleep Apnea
☐ CVA (Stroke)	☐ Lymphoma	☐ Spina Bifida
☐ Deep Vein thrombosis (DVT)	☐ Macular Degeneration	☐ Thyroid Disease
☐ Depression	☐ Malnourished	☐ Type I Diabetes
☐ Dermatitis	☐ Memory Loss	☐ Type II Diabetes
☐ Diabetic Neuropathy	☐ Mental Disorder	☐ Ulcerative Colitis
☐ Dialysis	☐ Mitral Valve Prolapse	☐ Urinary/Fecal Incontinence
☐ Diverticulitis	☐ Morbid Obesity	☐ Varicose Veins
☐ Dysphasia	☐ MRSA	☐ Venous Insufficiency
☐ Eating Disorder	☐ Multiple Sclerosis	☐ Cancer_____
☐ Other_____	☐ Other_____	☐ Other_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Day	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Surgical History: List any previous surgeries/hospitalizations and corresponding dates

Surgeries/Operations	Date	Hospitalizations (other than surgeries)	Date

Family History: Check all that apply.

Condition	Mother	Maternal Grandparents	Father	Paternal Grandparents	Sibling	Child	No History	Notes
Unknown History	☐	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	
Lung Disease	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	
None	☐	☐	☐	☐	☐	☐	☐	
Non Contributory	☐	☐	☐	☐	☐	☐	☐	

Social History

Weight:	Height:		Comments:
Have you ever smoked? ☐ Y ☐ N	How many years?	Packs per day?	Quit date:
Marital status :	Financial concerns? ☐ Y ☐ N		Comments:
Occupation:	Food, clothing, sheltering needs? ☐ Y ☐ N		Comments:
Completed Education Level:			
Children: ☐ Y ☐ N	Transport concerns? ☐ Y ☐ N		Comments:
Alcohol Use: ☐ None ☐ Rarely ☐ Occasionally ☐ Often			Comments:
Substance abuse ☐ Y ☐ N	Are you independent? ☐ Y ☐ N		Comments:
Glasses/Contacts ☐ Y ☐ N	Difficulty hearing? ☐ Y ☐ N		Comments:
Who do you live with?	Cultural or Religious Concerns? ☐ Y ☐ N		Comments:
Learning Method: ☐ Verbal ☐ Demonstration ☐ Written	Able to care for yourself? ☐ Y ☐ N		Comments:

If yes, please explain in the comments section